Within corporate limits

Recs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:

475 Goethe St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 475 Goethe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katherine Mary Aaron

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John D. Aaron

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 2, 1859

8. AGE:

Years	Months	Days	If less than one day
88	10	27	hrs. min.

9. Birthplace: Strattanville, Pa.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: James V. Jones

13. Birthplace: Pa.

MOTHER

14. Maiden name: Jane Cook

15. Birthplace: Pa.

16. Informant: James P. Aaron

Address: 3206 Windsor Ave. Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 2, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Oct. 2, 1948 (Date rec'd by registrar) W. R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 1948 at 1:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Sept 29 1948

and that I last saw h[illegible] alive on Sept 26 1948

Immediate cause of death: Myocardial Insuff 1 day

Due to: Arteriosclerosis 20 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 9/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

09001

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, Institution, or street address where death occurred:
home, 513 Decatur St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 513 Decatur St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Edna Rebecca Ault

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Hubert Ault

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 23- 1901

8. AGE: Years	Months	Days	If less than one day
46	10	3	..... hrs. ..... min.

9. Birthplace: Mt Savage, Md Allegany County
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: S

FATHER 12. Name: Daniel E.Norris

13. Birthplace: Harpers Ferry, W. Va.

MOTHER 14. Maiden name: Anna Kneirem

15. Birthplace: Meyersdale, Pa

16. Informant: Daniel E. Norris

Address: Mt Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/48 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt Savage, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept 28 19 48 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 19 48 at 6 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive Dead Sept. 26 19 48

Immediate cause of death: Acute pulmonary tuberculoses — DURATION: about 8 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed 9-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

09002

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 hours 3 minutes

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 38 hours 3 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #1, Box 190 - (National)

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Baer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of ~~husband of wife~~ Father Richard Baer

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 15 Sept 48

8. AGE: Years	Months	Days	If less than one day
		1	13 hrs. 3 min.

9. Birthplace Frostburg, Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Richard Baer

13. Birthplace Gilmore, Md

MOTHER 14. Maiden name Jane Kerling

15. Birthplace Fitzmiller, Md

16. Informant Richard Baer, Father

Address Rt #1, Box 190, Frostb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 17 Sept 48 (month) (day) (year)

Cemetery or crematory Laurel Hill Cem.

Location Mascan. Md.

18. Funeral director Family - Richard Baer

Address Rt #1, Box 190, Frostb. Md

19. 9-17 1948 Mrs. Nancy V. Rice

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1948 at 12 30 EST M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Sept 1948 to 17 Sept 1948

and that I last saw her alive on 17 Sept 1948

Immediate cause of death atelectasis — DURATION

Due to Prematurity - 3rd/3 at birth 2 6 lb 4 oz

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results None done -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Davis M. D.

Address Frostb, Md Date signed 9/17/48

N O I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09003

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Years

Hospital, institution, or street address where death occurred:
44 South Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 44 South St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cornelius Jackson Bageant

3.(b) Social Security Number 705-05-1784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Jessa Hovermale Bageant

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) April 26-1893

8. AGE: Years	Months	Days	If less than one day
55	4	14	hrs. min.

9. Birthplace Fredrick Co. Va.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Henry J. Bageant
13. Birthplace Fredrick Co. Va.

MOTHER
14. Maiden name Virginia Kerns
15. Birthplace Fredrick Co. Va.

16. Informant Mrs. C. J. Bageant (wife)
Address 44 South St. Cumberland Md.

17. Burial Date thereof Sept 13 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Sept 13 19 48 Nuter R. Gantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 19 48 at about 9 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h... in attended Dead Sept. 10 19 48

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to Coronary sclerosis	
Due to	
Other conditions Alcoholic	several years

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming
M. D. or other

Address Cumberland Md. Date signed 9-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09004 50

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Allegheny

City or town: Pittsburgh

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6045 Stanton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Barnard

3.(b) Social Security Number: 167-03-0682

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1886

8. AGE:

Years	Months	Days	If less than one day
62	4	21	..... hrs. ..... min.

9. Birthplace: Eckhart, Allegany, Maryland (town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Attorney's office

FATHER

12. Name: Michael Barnard

13. Birthplace: England

MOTHER

14. Maiden name: Mary Perry

15. Birthplace: England

16. Informant: Mrs. Joseph Goebel

Address: Johnsonburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17, 1948 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: J. R. Durst

Address: Frostburg, Md.

19. 9-16 1948 (Date rec'd by registrar) Mrs. Letticy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1948, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Sept 13 1948 and that I last saw h.. alive on Sept 14 1948

Immediate cause of death	DURATION
General Carcinomatosis	several months
Due to: Carcinoma of Breast	? ?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Breast Date of op. ? ?

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed: 9-13-48


RECEIVED
SEP 18 1948
BUREAU V. S.

Within corporate limits

Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49d

09005

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

410 Woodside Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Woodside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Geraldine Hope Brown

3. (b) Social Security Number 215-20-5881

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1925

8. AGE: Years	Months	Days	If less than one day
23	1	18	hrs. min.

9. Birthplace Dunbar, Fayette Co., Pa. (Town, county, and state)

10. Usual occupation Tube department

11. Industry or business K-S Tire Co.

FATHER 12. Name Gerald W. Brown

FATHER 13. Birthplace Dunbar, Pa.

MOTHER 14. Maiden name Della Baker

MOTHER 15. Birthplace Dunbar, Pa.

16. Informant Mrs. Della Brown

Address 410 Woodside Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1948 (month) (day) (year)

Cemetery or crematory Sylvan Heights Cemetery

Location Uniontown, Pa.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 9, 1948 (Date rec'd by registrar) W. A. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1948 at 12:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1947 to Sept. 7, 1948 and that I last saw her alive on Aug. 2, 1948

Immediate cause of death	DURATION
Carcinoma vulvae	18 mo.
Due to	
Due to	
Other conditions Carcinomatosis	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. D. Zimmerman M.D. M. D. or other

Address Date signed 9-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09006

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Polk St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carol Mae Carter

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 14, 1948

8. AGE: Years	Months	Days	If less than one day
0	0	18	____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Raymond C. Carter

13. Birthplace Port Richmond, Va.

MOTHER

14. Maiden name Bernice Coleman

15. Birthplace Cumberland, Md.

16. Informant Raymond C. Carter

Address 307 Polk St. Cumberland, Md.

17. Burial Date thereof 9-7-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 7 1948 W. R. Trautz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Aug 1948 to 1 Sept 1948 and that I last saw him alive on 1 Sept 1948.

Immediate cause of death	DURATION
Prematurity.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ____ Date of op. ____

Autopsy results Prematurity – Static Pneumonia Both Lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Fuller B. Hartwell M. D. or other

Address 112 Bedford St. Date signed 2 Sept 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09007

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 mo - 24 da

Hospital, Institution, or street address where death occurred:
119 S Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 S Lee St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Hall Combs

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Albert Combs

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 24 1886

8. AGE: Years: 62 | Months: — | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER — 12. Name: John Weeden

13. Birthplace: Md

MOTHER — 14. Maiden name: Catherine —

15. Birthplace: Md

16. Informant: Mrs Anatelle Hall

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21 '48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Sept 21 1948 (Date rec'd by registrar) W. L. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1948 at 5 15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1948 to Sept 18 1948 and that I last saw h— alive on Sept 17 1948

Immediate cause of death	congestive heart failure	DURATION: 6 months
Due to	Arteriosclerosis	2 years
Due to	Disease	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. M. Kings M.D.
M. D. or other

Address: 54 Greene St. Date signed: 9-18-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mr Bringo

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09008

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Cornwall Street, Ext.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cornwall St. Ext.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME William Cominsky

3. (b) Social Security Number 284-10-3104

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Frances Rezonee

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): — — 1886

8. AGE: Years: 62 | Months: — | Days: — | If less than one day: ...hrs. ...min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Coal Mining

11. Industry or business: Youghiogheny & Ohio Coal Co.

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Lithuania

16. Informant: Mrs. Stanley Duckworth

Address: Cornwall St. Ext. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 26 1948 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: Wm. E. Richhorn

Address: Lonaconing, Md.

19. 9-25-48 (Date rec'd by registrar) Mrs. Dewey N. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 23 1948 and that I last saw him alive on Sept 22 1948

	DURATION
Immediate cause of death: Chr Myocarditis	Several months
Due to: Cerebral Embolism	Sudden
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W.D.M. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed: 9-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09009

932

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Rural Flintstone

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Rural Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Susanna Dibert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William Dibert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 27, 1864

8. AGE:	Years	Months	Days	If less than one day
	83	11	10	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: Mathias G. Dean

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Emory

MOTHER — 15. Birthplace: Maryland

16. Informant: Florence Dibert

Address: Flintstone, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 11, 1948 (month) (day) (year)

Cemetery or crematory: Rush Cemetery

Location: near Flintstone, Md.

18. Funeral director: John J. Hoke

Address: Cumberland, Md.

19. Sept 11 1948 (Date rec'd by registrar) Nina L. Bendel. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1948, at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to Sept. 7 1948 and that I last saw her alive on July 20 1948

Immediate cause of death	DURATION
Myocardial failure	10 min
Due to: Chronic myocarditis	4 years
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur F. Jones M. D. M. D. or other

Address: 110 S. Centre St. Date signed 9-8-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ink correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

Murray 09010

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? — — —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nickolas Francis Dickel

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: deceased
6.(c) If alive, give age — — years

7. Birth date of deceased (mo., day, yr.): Feb. 26-1863

8. AGE: Years	Months	Days	If less than one day
85	6	14	— hrs. — min.

9. Birthplace: Mt. Savage Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Car-man C.&P.R.R.
11. Industry or business: Railroad

FATHER
12. Name: Michael Dickel
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Staal
15. Birthplace: Germany

16. Informant: Joseph Dickel
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11-1948 (month) (day) (year)
Cemetery or crematory: St. Patricks
Location: Mt. Savage, Md.

18. Funeral director: J. K. Grant
Address: Frostburg, Md.

19. Sept. 10 1948 (Date rec'd by registrar) Vernon A. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1948, at 6 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1948 to Sept 9 1948
and that I last saw h.. alive on Sept 14 1948

Immediate cause of death	DURATION
Senility - Senile Debility 3 hours	
Due to: Chronic Myocarditis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Allen G. Mann M. D. or Other
Address: Cumberland Md. Date signed: Sept 10 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09011

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43

Hospital, institution, or street address where death occurred:

Reeves Clinic

How long in hospital or institution? Died in office while waiting to be treated

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Smoot St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Jonathan Dixon

3. (b) Social Security Number: 213-18-2157

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred Shaffer Dixon

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): April 17, ~~1848~~ 1905

8. AGE:

Years	Months	Days	If less than one day
43	5	7	...hrs. ...min.

9. Birthplace: Shaw, Mineral Co. West Virginia (Town, county, and state)

10. Usual occupation: Millwright

11. Industry or business: W Va. pulp & paper Co

FATHER

12. Name: Alfred Dixon

13. Birthplace: Unknown

MOTHER

14. Maiden name: Elizabeth Bunce

15. Birthplace: Unknown

16. Informant: Mrs Mildred S. Dixon

Address: 216 Smoot St. Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport Md

18. Funeral director: Ellsworth & Beal

Address: Westernport Maryland.

19. Sept 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1948, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw him alive on Sept 24 1948

Immediate cause of death	DURATION
Chronic myocarditis	1 1/2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D.

M. D. or other

Address: Cumberland, Md. Date signed: 9-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

69012

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Thirty Minutes

Hospital, Institution, or street address where death occurred:
23 Henderson Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Henderson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Edwards

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 23 1948

8. AGE: Years | Months | Days | If less than one day: 30 min.

8. Birthplace: Cumberland, Md. Allegany Co
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Matthew Edwards

FATHER — 13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Mary Mort

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Matthew Edwards

Address: 23 Henderson Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/48 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: C umberland, Md.

19. Sept. 25, 1948 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1948 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Premature — DURATION: 3 wks.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay E. Furrow M. D. or other

Address: Cumberland Date signed: 9/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164C

09013

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town ~~Gilpentown Md.~~ Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 12 Hours

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? about 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Gilpentown
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war World War II

3.(a) FULL NAME Charles Ralph Elbin

3.(b) Social Security Number 214-07-6258

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Hazel M.D.Elbin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 13- 1912

8. AGE: Years	Months	Days	If less than one day
36	5	12	..... hrs. ..... min.

9. Birthplace Inglesmith Pa.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name John Elbin

13. Birthplace Bedford Co. Pa.

MOTHER 14. Maiden name Willie Smith

15. Birthplace Bedford Co. Pa.

16. Informant Fred R. Elbin

Address Warfordsburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29, 1948 (month) (day) (year)

Cemetery or crematory Fairview Christian Cemetery

Location Artemas, Pa.

18. Funeral director John A. Hafer

Address Cumberland, Md.

19. Sept. 28, 1948 (Date rec'd by registrar) W.R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 19 48 at 8.30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Sept. 25 19 48

Immediate cause of death: Intracranial hemorrhage — DURATION: 19 hrs.

Due to: Self inflicted by a 32 caliber automatic revolver.

Due to: drink & jealously.

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-25-48

Where did injury occur? Gilpentown (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Manner of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 9-25-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

09014

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Gilpentown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 1 yr.

Hospital, institution, or street address where death occurred:
home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Gilpentown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Star Route
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Hazel Maude D. Elbin

3.(b) Social Security Number: 214-07-3873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Charles Ralph Elbin

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): May 24 1912

8. AGE: Years	Months	Days	If less than one day
36	4	1	...hrs. ...min.

9. Birthplace: Old Town Md.
(Town, county, and state)

10. Usual occupation: Textile worker

11. Industry or business: Celanese Corp. of Am.

FATHER
12. Name: James Walter Miller
13. Birthplace: Berkley Springs W.Va.

MOTHER
14. Maiden name: Bertha Custer
15. Birthplace: Berkley Springs W.Va.

16. Informant: Mother) Mrs. Bertha Miller
Address: Old Town Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Tabor Cem.

Location: Old Town Road

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Sept. 28, 1948 (Date rec'd by registrar) Nina L. Bender. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 19 48 at about 1.30A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19... to ...19...

and that I last saw her alive Dead Sept 25 19 48

Immediate cause of death: Intracranial hemorrhage — DURATION: at once

Due to: head wounds, from a 32 automatic revolver, fired by her

Due to: husband.

Other conditions: bullet wound in left side of pelvis.
(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of: 9-25-48

Where did injury occur? Gilpentown (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: as above Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. (M. D. or other)

Address: Cumberland Md. Date signed: 9-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line 6 (c) if living is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH ~~Dr. J. H. Wolverton, Jr.~~ 03013

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 6

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred: 122 Railroad Street

How long in hospital or institution? - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Railroad St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: NELLIE RAY FIELD

3. (b) Social Security Number: - - - - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Watson Field

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): October 20, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	17	...hrs. ...min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER 12. Name: John Phillips

FATHER 13. Birthplace: Wales

MOTHER 14. Maiden name: Minara Miller

MOTHER 15. Birthplace: Barton, Maryland

16. Informant: Karl Field

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Sept. 10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1948 at 10:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1948 to Sept 7 1948

and that I last saw her alive on Sept 6 1948

Immediate cause of death	DURATION
Pulmonary Edema	1 Day
Due to Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	2 Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul H. Wilson M.D.

M. D. or other

Address: Piedmont W. Va. Date signed: 9-10-48

Within corporate limits JACOBSON

09016

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA. County MINERAL

City or town FORT ASHBY
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME MRS. CORA FLORA

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JOHN WM. FLORA 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 3-25-94

8. AGE: Years	Months	Days	If less than one day
54	5	12	....hrs. ....min.

9. Birthplace keyser, W. va.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name HARRISON, SAMUEL
13. Birthplace W. VA.

MOTHER
14. Maiden name HARDY, MARY ELLEN
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 '48 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland Md

19. Funeral director Louis Stein Sons

Address Cumberland Md

19. Sept 10 19 48 (Date rec'd by registrar) WR-Crawley, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 19 48 at 7:45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 5 19 48 to Sept. 7 19 48

and that I last saw h.. alive on Sept. 7 19 48

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Hypertensive cardiovascular disease	2
Due to	....
Other conditions Diabetes Mellitus	2

(Include pregnancy within 3 months of death)

Major findings of operation .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or other

Address 50 Pershing St Date signed 9/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

M 69017

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 64 Spring Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Alphonsus Footen

3.(b) Social Security Number: 219-03-9036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Clare Footen
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 24, 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	3	20		

9. Birthplace: Frostburg Allegany Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Planing mill

FATHER
12. Name: John H. Footen
13. Birthplace: unknown

MOTHER
14. Maiden name: Elizabeth Cullen
15. Birthplace: unknown

16. Informant: Joseph Footen
Address: Frostburg, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 17 1948
(month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg Md

18. Funeral director: J. R. Dieret
Address: Frostburg, Md.

19. 9-16 1948 Mrs. Nancy N. Rice
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1948 at 3:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 1948 to Sept 14 1948 and that I last saw h.e.r. alive on Sept 13 1948

Immediate cause of death: Chronic Myocarditis — DURATION: Several years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. C. Lane M.D.
M. D. or other
Address: Frostburg Md Date signed: 9-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09018

47a

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Grant

City or town: Riley's Ford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Foreman

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Gormer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7 1870

8. AGE: Years: 78 Months: 3 Days: 25 If less than one day: ..... hrs. ..... min.

9. Birthplace: Harpers Ferry W. Va.

(Town, county, and State)

10. Usual occupation: Odd jobs - Laborer

11. Industry or business: Retired.

FATHER

12. Name: James Foreman

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Anna Gentry

15. Birthplace: W. Va.

16. Informant: Miss Clara Foreman

Address: 452 Balto. Ave Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Sept. 4, 1948 (Date rec'd by registrar) W. R. Fautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1948, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 10th 1948, to Sept 2 1948

and that I last saw h.. alive on Sept 2nd 1948

Immediate cause of death	DURATION
Shock	
Cardiac Failure following	
Operation (Gastrostomy)	
Due to Obstruction of Esophagus	
Due to Extrinsic Carcinoma of Larynx	
Other conditions Metastasis in both Lungs.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of opp. .....

Autopsy results: Carcinoma Larynx, Lungs, Myocardium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Leslie E Daugherty M.D.

M. D. or other

Address: 7 Washington Cumberland Maryland Date signed: 9-2-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09019

552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
111 1/2 Blaul Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 111 1/2 Blaul Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mahulda Beck Garland

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11-1893

8. AGE: Years	Months	Days	If less than one day
54	9	9	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Phillip Beck
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Linderman
15. Birthplace: ?

16. Informant: Rosie Vulgamott

Address: 109½ Blaul Ave.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 23 1948
(month) (day) (year)

Cemetery or crematory: Mt. Tabor Cemetery

Location: Oldtown Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Sept 21 1948 W. L. Trautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 19 48 at 10.10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive Dead Sept. 20 19 48

Immediate cause of death	DURATION
Adenocarcinoma	about 6 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

~~Deputy Medical Examiner - Allegany Co.~~

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 9-20-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09020

181

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. BOWMANS ADDITION

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

F

WILLIAM GENTRY

3.(b) Social Security Number 220-10-2791

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARIE CORRIGAN

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) March 10-1901

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	5	26		

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation TRACKMAN B&O.R.Ry

11. Industry or business BALTIMORE AND OHIO RAILROAD

FATHER 12. Name DAVID S. GENTRY

13. Birthplace ~~VA~~. Rockingham City, Va.

MOTHER 14. Maiden name SARA ELIZABETH METZ

15. Birthplace MARYLAND.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 48 (month) (day) (year)

Cemetery or crematory Philos Cem.

Location Westernport 2nd

18. Funeral director Louis Stein Inc

Address Cumberland

19. Sept. 8, 19 48 (Date rec'd by registrar) C.R. Kautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 6, 48 2:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Sept. 6 19 48

Immediate cause of death 2nd. & 3rd. degree burns of face, neck chest, back & both arms & hands — DURATION 8 days

Due to

Due to explosion of an overheated torch, wick forced through air

Other conditions about 5 ft. which caused his clothes to catch fire.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-29-48

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) B&O.R.Ry.

Means of injury as above Injured at work? Yes

23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D. (M. D. or other)

Address Cumberland Md. Date signed 9-6-48

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09021

932

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Ward Parr Paw

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: On way to Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W Va. County: Morgan

City or town: Parr Paw

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jennie E Golladay

3. (b) Social Security Number None

4. Sex: F

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jacob F Golladay

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 12, 1867

8. AGE: Years: 81 Months: 7 Days: 22 If less than one day: hrs. min.

9. Birthplace: Bedford Pa

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: At Home

FATHER 12. Name: William Fletcher

13. Birthplace: Bedford Co. Pa

MOTHER 14. Maiden name: Sarah Smith

15. Birthplace: Bedford Co. Pa.

16. Informant: Hazel Golladay

Address: Parr Paw W Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1948 (month) (day) (year)

Cemetery or crematory: Camp Hill Cem.

Location: Parr Paw W Va.

18. Funeral director: W. L. Parks

Address: Berkley Springs W Va.

19. Sept. 5 1948 (Date rec'd by registrar) W. K. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17 1948 to Sept 4 1948 and that I last saw her alive on August 28 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Hypertension Cardio-vascular Disease	?
Due to:	
Other conditions: Arteriosclerosis	8 Yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Berkley Springs W Va. Date signed: 9/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09022

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, institution, or street address where death occurred: - - - - - - - - -
How long in hospital or institution? - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No. - - - - - -
(If rural, give LOCATION)
2.(a) If veteran, name war - - - - - -

3. (a) FULL NAME: JAMES GOWANS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Dye Gowans
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): September 19, 1897

8. AGE: Years: 50 Months: 11 Days: 14 If less than one day: ... hrs. ... min.

9. Birthplace: Osecola Mills, Clearfield, Pa. (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Grocery Store

FATHER
12. Name: George Gowans
13. Birthplace: Scotland

MOTHER
14. Maiden name: Jennie Lees
15. Birthplace: Scotland

16. Informant: Anna Dye Gowans
Address: Barton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3, 1948 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Maryland

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. Sept 2 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1948 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/25 19 48 to 9/1 19 48
and that I last saw him alive on 9/1 19 48

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to arteriosclerosis	1 yr
Due to	
Other conditions Hypertension	3 mo

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: F E Berry M D (M. D. or other)
Address: Piedmont W Va Date signed: 9/1/48

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46c

09023

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 wk.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 wk.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Springs (If outside city or town limits, write RURAL and give nearest town)

Street No. 733 Easley St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry M. Hawkins.

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Annie McDonald

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb - 1866

8. AGE: Years: 82 Months: 7 Days: — If less than one day: hrs. min.

9. Birthplace: Charles Co. Md. (Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Construction.

FATHER 12. Name: Samuel Hawkins

13. Birthplace: Charles Co. Md

MOTHER 14. Maiden name: Jane Robertson

15. Birthplace: Charles Co Md

16. Informant: Dr. A. H. Hawkins.

Address: Cumberland

17. Burial + Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 16 '48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cem.

Location: Gaithersburg, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Sept. 16, 1948 (Date rec'd by registrar) W. L. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16. 1948 at 3 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Sept 16 1948 and that I last saw h... alive on Sept 15 1948

	DURATION
Immediate cause of death: Exhaustion	
Due to: following Operation for Carcinoma of Ampulla	Some
Due to: Papilla of Vater	6 D
Other conditions: Papilla of Vater	Ok.

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Papilla of Vater Date of op. 9-13-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. H. Hawkins M. D. or other

Address: Cumberland Date signed: 9-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

467

09024

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:
Allegany Hospital, 215 Decatur St., Cumb., Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: R. #5, Cumberland, Maryland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #5, [illegible]
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mrs. Jane Horton

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Horton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18th, 1886

8. AGE: Years	Months	Days	If less than one day
62	6	15	..... hrs. ..... min.

9. Birthplace: Frostburg, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Lewis
13. Birthplace: Eckhart, Md.

MOTHER
14. Maiden name: Mary Thomas
15. Birthplace: Hazelton, Pa.

16. Informant: Lewis Horton
Address: R.D.#5, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5th, 1948 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Hafer Frostburg, Md.
Address: 23 East Main Street

19. Sept. 5, 1948 (Date rec'd by registrar) W. R. Tantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/3 1948, at 9:12 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-1- 1948, to 9/3 1948, and that I last saw h... alive on 9-2- 48 1948

	DURATION
Immediate cause of death: Cancer of the gallbladder	6 months
Due to: Cancer of liver, secondary	5 days
Due to: Chronic illness	5 years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Metastatic carcinoma of liver, on gallbladder Date of op. 8-18-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. Weiss MD
M. D. or other

Address: 59 Green St Date signed: 9-3-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 C

09025

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Home) 501 Decatur St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and giva nearest town)

Street No. 501 Decatur St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Harry W. Jones

3.(b) Social Security Number

220 10 1555

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Izora E Ziler Jones

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Aug. 3- 1865

8. AGE: Years	Months	Days	If less than one day
83	1	27	....hrs. ....min.

9. Birthplace Cumberland Md. (Allegany)
(Town, county, and state)

10. Usual occupation retired

11. Industry or business Celanese Corp. of America

FATHER 12. Name Thomas H. Jones

FATHER 13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Mary A. Litzenburg

MOTHER 15. Birthplace Cumberland Md.

16. Informant Mrs. Izora Jones

Address 501 Decatur St. Cumberland Md.

17. Burial Date thereof Oct. 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Oct 2 1948 W. R. Trauty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 19 48 at 6.15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h. im Dead Sept. 30 19 48

Immediate cause of death	DURATION
Intracranial hemorrhage	at once
Due to a self inflected bullet wound from a 32 caliber revolver	
Due to worry & poor health.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-30-48

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury as above Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M. D.
M. D. or Coroner

Address Cumberland Md. Date signed 9-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45c

09026

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten Years

Hospital, Institution, or street address where death occurred: 54 Thomas St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 54 Thomas St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John Warfield Judy

3. (b) Social Security Number: 220-07-6695

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-7-1884

8. AGE:	Years	Months	Days	If less than one day
	64	5	13	hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER — 12. Name: William E Judy

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Maria Spatz

15. Birthplace: Brooklyn, N.Y.

16. Informant: Eva B. See.

Address: 57 Thomas St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-22-48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John T Walford

Address: Cumberland md

19. Sept 22 1948 (Date rec'd by registrar) Hunter A Zent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948, at 7 17 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-16-1947, to 9-18-1948 and that I last saw h[illegible] alive on 9-18-1948

Immediate cause of death	DURATION
Causes of the flues	2 years
of the month	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C Klinge M.D. M. D. or other

Address: 59 Greene St. Date signed: 9-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09027

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BABY BOY KENDALL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 7, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace CUMBERLAND, ALLEGANY, MARYLAND (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER — 12. Name EDGAR a KENDALL

13. Birthplace Boydsman, Penna.

MOTHER — 14. Maiden name BETTY HUSTED

15. Birthplace Pittsburgh, Penna

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1948 (month) (day) (year)

Cemetery or crematory Boydsman

Location Boydsman, Penna

18. Funeral director John J. Hafer

Address Boydsman, Penna

19. Sept. 9 1948 (Date rec'd by registrar) C.R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7 1948 to Sept. 8 1948 and that I last saw him alive on Sept. 8 1948

	DURATION
Immediate cause of death Pulmonary Atelectasis	24 hrs.
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of operation .....

Autopsy results Pulmonary Atelectasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Pierce Hodges M. D. or other

Address Cumberland, Md. Date signed 9/9/48

Within corporate limits

TOPPER
TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

09028

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or Institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. REAR 412 CHESTNUT ST
(If rural, give LOCATION)
2.(a) If veteran, name war 1st World War

3.(a) FULL NAME KLEIN, RUSSELL H. MR

3.(b) Social Security Number 214-07-0300

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife RUEHL, ANNA 6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 6 1892

8. AGE: Years	Months	Days	If less than one day
55	10	12	..... hrs. ..... min.

9. Birthplace MARYLAND, Conniganville, Md. (Town, county, and state)
10. Usual occupation CARPENTER
11. Industry or business Kelly Tire Co., Cumb. Md.
FATHER 12. Name KLEIN, FREDERICK H
13. Birthplace W. VA
MOTHER 14. Maiden name DEFFENBAUGH, IDA
15. Birthplace MD, Conniganville, Md.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1948 (month) (day) (year)
Cemetery or ~~crematory~~ Greenmount
Location Cumberland Md.
18. Funeral director Jacob Naper
Address Lonaconing, Md.
19. Sept. 20, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18- 1948, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-4- 1948 to 9-18- 1948 and that I last saw h.i. alive on 9-18- 1948

	DURATION
Immediate cause of death Chronic glomerular nephritis	4 years?
Due to	
Due to	
Other conditions Benign Hypertrophy Prostate.	

(Include pregnancy within 3 months of death)

Major findings of operations no operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson, M.D. M. D. or other
Address Cumberland, Md. Date signed 9-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124a 09029

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
In route, in ambulance to Memorial

How long in hospital or institution? Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Valley Road, R.F.D. #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME W. Monroe Kreger

3.(b) Social Security Number 178-07-1658

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29- 1903

8. AGE: Years	Months	Days	If less than one day
45	3	12	hrs. min.

9. Birthplace Confluence Pa.
(Town, county, and state)

10. Usual occupation barber

11. Industry or business

FATHER 12. Name Samuel Kreger

13. Birthplace Confluence Pa.

MOTHER 14. Maiden name Frances Lingenfelter

15. Birthplace Confluence Pa.

16. Informant (sister) Betty E. Kreger

Address Valley Rd. Cumberland Md.

17. Burial Date thereof Sept 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jersey Church Cemetery

Location Confluence, Pa.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Sept 13 1948 Hunter R. Trout, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 19 48 at 1.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive Dead Sept. 11 19 48

Immediate cause of death	DURATION
Ruptured esophageal varicoses	?
Due to cirrhosis of the liver	
Due to	
Other conditions alcoholic	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. Deputy Medical Examiner - Allegany Co. H.V. Deming M.D.
M. D. or Coroner

Address Cumberland Md. Date signed 9-11-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09030

93d

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County: Columbiana

City or town: Leetonia

(If outside city or town limits, write RURAL and give nearest town)

Street No. 172 Chestnut

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: George Wm. Kreitzburg

3.(b) Social Security Number: 705-05-3972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary McGraw

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 29, 1876

8. AGE: Years 72 | Months 1 | Days 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Allegany Co. Md. (Town, county and state)

10. Usual occupation: Retired Machinist Helper

11. Industry or business: B & O. Railroad

FATHER — 12. Name: George Kreitzburg

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sarah Lyons

MOTHER — 15. Birthplace: Unknown

16. Informant: Alleg. Co. Infirmary

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 28 1948 (month) (day) (year)

Cemetery or crematory: St Michaels Cemetery

Location: Frostburg Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 27, 1948 (Date rec'd by registrar) W. R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1948, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept. 25 1948 and that I last saw him alive on Sept. 24 1948

Immediate cause of death	DURATION
Acute Myocardial failure	5 min
Due to: Chr. Myocarditis	6 yrs
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 9-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09031

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

734 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 734 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rose Cecelia Kreyglaum

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1870

8. AGE: Years	Months	Days	If less than one day
78	1	—	hrs. min.

9. Birthplace Connellsville Pa.

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER 12. Name Peter Kreyglaum

13. Birthplace Ind.

MOTHER 14. Maiden name Mary Mc Bride

15. Birthplace Ind.

16. Informant Mrs W. E. Arnold

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 48 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Sept. 3 1948 W. R. Trautz M. D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 11.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept 1 1948 and that I last saw her alive on Sept 1, 1948

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Myocardial degeneration	
Due to Bronchitis, acute	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. M. Simon M. D. or other

Address 124 Union St Date signed Sept 1, 1948

PLEASE WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH Dr P R Wilson 09032

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Weeks

Hospital, institution, or street address where death occurred:
102 Main Street

How long in hospital or institution? - - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County: Franklin

City or town: Colombus
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1469 Lincoln Road
(If rural, give LOCATION)

2.(a) If veteran, name war: - - - - - - - -

3.(a) FULL NAME: RICHARD MICHAEL LAUGHLIN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jean Malcolm Laughlin

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): June 3, 1872

8. AGE: Years	Months	Days	If less than one day
76	3	7	....hrs. ....min.

8. Birthplace: Franklin, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: - - - - - -

FATHER
12. Name: John Laughlin
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ellen Byrne
15. Birthplace: Ireland

16. Informant: Patrick L. Laughlin
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13 1948 (month) (day) (year)

Cemetery or crematory: St Peters Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Sept. 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 1948 at 2:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Sept 10 1948 and that I last saw h.i.m. alive on Sept. 10 1948

	DURATION
Immediate cause of death: Chronic Nephritis Unspecified	10 Years
Due to: Arteriosclerosis and Hypertension	10 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

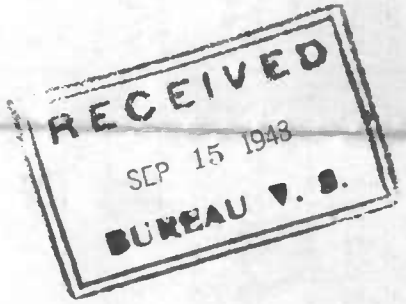
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul R Wilson M.D. M. D. or other

Address: Piedmont W. Va. Date signed: 9-11-48


RECEIVED
SEP 15 1948
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

09033

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Corrigansville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harris G. Lowery

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Sarah Clites Lowery

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April- 21 -1884

8. AGE: Years	Months	Days	If less than one day
64	4	14	...hrs. ...min.

8. Birthplace Pa.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name Emanuel Lowery

13. Birthplace Pa.

MOTHER 14. Maiden name Sarah Witt

15. Birthplace Pa.

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept. 9, 1948
(month) (day) (year)

Cemetery or crematory Porter Cem.

Location Hyndman, Penna.

18. Funeral director Harvey H. Zeigler,

Address Hyndman, Penna.

19. Sept. 7 19 48 M. R. Lantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 19 48 at 3.05A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw him alive on Dead Sept. 5 19 48

Immediate cause of death	DURATION
Subdural hemorrhage	2 days
Due to a fracture of the skull	
Due to an accident	
Other conditions Lobar pneumonia, base of right lung.	about 2 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident ? Date of 9-3-48

Where did injury occur? Corrigansville, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Found lying near B&O R.Ry tracks

Means of injury ? Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 9.5.48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09034

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three Years

Hospital, Institution, or street address where death occurred: 107 Decatur Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 Decatur Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Ellen Luteman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Tice M. Luteman

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 2 1865

8. AGE: Years	Months	Days	If less than one day
82	9	16	____ hrs. ____ min.

9. Birthplace: Berkley Springs, W. Va.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: Henry Bohrer

FATHER — 13. Birthplace: Berkley Springs, W. Va.

MOTHER — 14. Maiden name: Durana Henry

MOTHER — 15. Birthplace: Berkley Springs, W. Va.

16. Informant: Mrs. James Bucy

Address: 107 Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/48 (month) (day) (year)

Cemetery or crematory: Duckwall Cemetery

Location: Berkley Springs, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 20 19 48 (Date rec'd by registrar) W. L. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 19 48 at 8-30 A M

21. I CERTIFY that death occurred on the date above, stated, that I attended deceased from 19 ____ to Sept 18 19 48 and that I last saw h[illegible] alive on Sept 17 19 48

Immediate cause of death	DURATION
Myocardites	1 year
Due to	
Due to	
Other conditions: Chronic Arthritis	3 years
Arteriosclerosis	3 years

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D.
M. D. or other

Address: Cumberland Md Date signed 9-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09035

61

FILM No. G 117 SEP 21 1948

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miner's Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Center St. Ext.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Robert Lee Mackenzie

3. (b) Social Security Number: 298-09-7836

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nellie Wasler
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 15 - 1893

8. AGE: Years	Months	Days	If less than one day
54 yrs	0	6	____ hrs. ____ min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Leather Worker

FATHER
12. Name: Wm. J. Mackenzie
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Maria Lauder
15. Birthplace: England

16. Informant: Mrs. James Lancaster
Address: 4 Centennial St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12 - 1948 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: Jacob Harper
Address: Frostburg, Md.

19. 9-11 1948 (Date rec'd by registrar) Miss Nancy K. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/9 1948 at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9 1947 to 9/9 1948
and that I last saw h. im alive on 9/9/48 1948

Immediate cause of death	DURATION
Cerebral thrombosis	1 hr
Due to: Generalized arteriosclerosis	15 yrs±
Due to: Diabetes Mellitus	11 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M. D. or other
Address: 57 E. Main St. Frostburg, Md. Date signed: 9/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1572

09036

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital, Frostburg

How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME REDA MARIE Main

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	child

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 4th 1948

8. AGE: Years	Months	Days	If less than one day
—	—	—	8 hrs. ... min.

9. Birthplace Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Main

13. Birthplace Lonaconing, Md

MOTHER 14. Maiden name Mary Grey

15. Birthplace Midland, Md

16. Informant William Main

Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5 1948 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetary

Location Lonaconing, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. 9-5 1948 Mrs Nancy N. Rae (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 July Sept 1948 at 10 30 p. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4 Sept 1948 to 4 Sept 1948 and that I last saw her alive on 4 Sept 1948

Immediate cause of death	DURATION
atelectasis	
Due to Congenital Heart	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE John B. Davis M. D.

Address Frostb., Md Date signed 9/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City limits

09038

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland - Route 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, institution, or street address where death occurred: Rt. 1, Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. LaVale - Rt. 1, E
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Rachel "Miller" Marriott

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Paul W. Marriott

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 13, 1862

8. AGE: Years	Months	Days	If less than one day
86	4	21	____ hrs. ____ min.

9. Birthplace: Garrett Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: William H. Miller
13. Birthplace: ? Md.

MOTHER
14. Maiden name: Dorcas Duckworth
15. Birthplace: ? Md.

16. Informant: Oliver S. Marriott
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 6 (Date rec'd by registrar) 19 48 W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6, 19 48 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 19 48, to Sept 3 19 48 and that I last saw her alive on Sept 3 19 48

Immediate cause of death: Carcinoma of Stomach — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charlotte B. Gardner M.D.
M. D. or other

Address: 136 Columbia St, Cumberland Date signed: Sept 6, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Eliason

09037

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:
10 Mary St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Mary St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Eugene Mc Elfish

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1928

8. AGE: Years	Months	Days	If less than one day
19	9	14	hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business School

FATHER
12. Name Thomas E. Mc Elfish
13. Birthplace Rush, Md

MOTHER
14. Maiden name Bertha Carder
15. Birthplace Romney, W. Va.

16. Informant Thomas E. Mc Elfish
Address Rt 4, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1948 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept 21 1948 (Date rec'd by registrar) W. K. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1948 to Sept 18 1948

and that I last saw h[illegible] alive on Sept. 12 1948

Immediate cause of death	DURATION
Encephalomeningitis	10 yr.
Myocarditis	10 yr.
Due to Chronic Nephritis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. K. Fauntz M.D. M. D. or other

Address 126 Penn St Cumberland (Md.) Date signed 9/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

09039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 Yrs 5 Mo 3 Days

Hospital, institution, or street address where death occurred:
709 Gephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 709 Gephart Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edythe McGady

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William J. McGady

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): April 23 1876

8. AGE: Years	Months	Days	If less than one day
72	5	7	..... hrs. ..... min.

9. Birthplace: Cumberland, Md. Allegany Co.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Joseph Hughes
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Minna Damm
15. Birthplace: Berlin, Germany

16. Informant: William J. McGady
Address: 709 Gephart Drive, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept 28 1948 (Date rec'd by registrar) W. H. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1948, at 11-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25th. 1948 to Sept. 25 1948 and that I last saw h[illegible] alive on Sept. 25th. 1948

Immediate cause of death	DURATION
Coronary Thrombosis	2 Hrs.
Due to	
Due to	
Other conditions: Hypertension	?
Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James E. McLean M.D.
M. D. or other

Address: 49 Greene St. Date signed: 9-27-48

Within corporate limits

09040

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 - 3

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 340 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Olivia Greskins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Chas Greskins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1 1879

8. AGE: Years	Months	Days	If less than one day
69	—	3	..... hrs. ..... min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home.

FATHER 12. Name Henry Dolle

13. Birthplace Md.

MOTHER 14. Maiden name Ellen —

15. Birthplace Md.

16. Informant Mrs James Grau

Address Cumberland

17. Burial Date thereof Sept 7 '48

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Summer Grn

Location Cumberland.

18. Funeral director Louis Stein Sons

Address Cumberland

19. Sept 7 1948 W R Frantz M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1948 to Sept 4 1948

and that I last saw h... alive on Sept 4 1948

	DURATION
Immediate cause of death Acute Coronary occlusion	2 hours
Due to Arteriosclerotic heart disease	6 months
Due to 420.0	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W R Frantz M.D.

M. D. or other

Address 54 Green St. Date signed 9-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Bump

Within corporate limits

09041

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Evidence for change of age shown on:

FILM No. G 117 OCT 4 1948

1. PLACE OF DEATH:

County Allegany

City or town Cumberland #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garrett

City or town Avilton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maggie Michael

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Earnest Q. Michael

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): October 22-1878

8. AGE: Years	Months	Days	If less than one day
69 66	II	I	Hrs. Co. Min.

9. Birthplace: Near Gilmore, Alleg Co. Md (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

FATHER — 12. Name: Thomas Llewellyn

FATHER — 13. Birthplace: Near Gilmore, Md.

MOTHER — 14. Maiden name: Mary McKenzie

MOTHER — 15. Birthplace: Ralleys, Md

16. Informant: Earnest Q. Michael

Address: R.D.I. Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-25-1948 (month) (day) (year)

Cemetery or crematory: Mount Zion

Location: 7 Miles East Of Grantsville On R*40

18. Funeral director: Wm Winterberg

Address: Grantsville Md

19. Sept 24 1948 W. L. Sauble M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1948, at 5:15a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26- 1945, to 9-23- 1948 and that I last saw h.. alive on 9-22- 1948

	DURATION
Immediate cause of death: apoplectic Stroke	6 days
Due to: cerebral arteriosclerosis	1 yrs
Due to: generalized arteriosclerosis	2 yrs
Other conditions: Arteriosclerotic heart disease	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: / Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: / Injured at work?

23. SIGNATURE: L. Phillips M.D. M. D. or other

Address: 59 Green St. Date signed 9-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09042

131a

Reg. Diat. No. 4

DR JACOBSON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 68 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 BEALL ST
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES MIGNOT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: ANNIE GREIDER

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): NOV. 6, 1868

8. AGE: Years: 79 Months: 10 Days: 19 If less than one day: ____ hrs. ____ min.

9. Birthplace: Pa. Clearfield Co. Penna.
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business: W. Md. R.R. CO.

FATHER
12. Name: JOHN MIGNOT
13. Birthplace: FRANCE

MOTHER
14. Maiden name: TRESSIR LEHIR
15. Birthplace: Germany

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28, 1948 (month) (day) (year)
Cemetery or crematory: St. Mary's Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Sept. 28, 1948 (Date rec'd by registrar) W. L. Gantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT 25 1948, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1948 to Sept 25 1948 and that I last saw h... alive on Sept 25 1948

Immediate cause of death: Myocardial Failure — DURATION: 6 Hrs.

Due to: Hypertensive Cardiovascular renal disease

Due to: Mitral Insufficiency & Stenosis

Other conditions: Complete Heart Block. Auricular Fibrillation
(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 57 Bowdoin St. Date signed: 9/27/48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09043

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address (if not in hospital) where death occurred:

119 S. Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 S. Lee St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary E Mitchell

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Charles A. Mitchell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1876

8. AGE: Years: 72 | Months: — | Days: | If less than one day: ..... hrs. ..... min.

8. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business: At Home

FATHER

12. Name: Henry Stall.

13. Birthplace: Md

MOTHER

14. Maiden name: Ellen —

15. Birthplace: Md

16. Informant: Mrs James Grant

Address: Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 20 48 (month) (day) (year)

Cemetery or crematory: Summer Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Jne

Address: Cumberland

19. Sept 20, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 17 1948 and that I last saw her alive on Aug 2 1948

Immediate cause of death	DURATION
Acute Myocardial Failure	5 min.
Due to Chronic Myocarditis	3 yrs
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M. D.

M. D. or other

Address 110 S. Centre St. Date signed 9-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09044

93d

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Broadway

(If rurol, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Frank J. Nairn

3.(b) Social Security Number 216-01-8838

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mary Nairn

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): April 20th, 1882

8. AGE:

Years	Months	Days	If less than one day
66	5	8	...hrs. ...min.

9. Birthplace: Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Pipe Fitter

11. Industry or business: Celanese Corporation

FATHER
12. Name: Jacob Nairn
13. Birthplace: Nova Scotia

MOTHER
14. Maiden name: Jane McGann
15. Birthplace: Frostburg, Maryland

16. Informant: Mrs. Frank J. Nairn

Address: 25 Broadway, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/48 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Maryland

18. Funeral director: Jacob Hafer

Address: Frostburg, Maryland

19. 9-30 1948 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 29 1948 at 1:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 28 1948, to SEPT. 29 1948

and that I last saw h/M alive on SEPT. 29 1948

	DURATION
Immediate cause of death: CORONARY THROMBOSIS -- ACUTE - MASSIVE	3 HRS.
Due to: MYOCARDITIS - CHRONIC	1 YR.
Due to: AURICULAR FIBRILLATION	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Mark Lieb Rothstein, M.D. M. D. or other

Address: 48 Broadway - Frostburg, Md. Date signed 9/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate cottage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 D

09045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

T

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31/2 years

Hospital, Institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 31/2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Jesse Park

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1872

8. AGE: Years	Months	Days	If less than one day
76	—	~~70~~	...hrs. ...min.

9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Domestic Work

11. Industry or business: Mother's Home

FATHER — 12. Name: James Park

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Marion Cunningham

MOTHER — 15. Birthplace: Scotland

18. Informant: James Park

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18 1948 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: D. Eichhorn

Address: Lonaconing, Md.

19. Sept 17 1948 (Date rec'd by registrar) J. R. Feaut, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1948, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1946 to Sept. 16 1948

and that I last saw h.er alive on Sept. 14 1948

Immediate cause of death: Uremia — DURATION: 6 wks

Due to: Chr. Glomerular Nephritis — 2 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 9-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

09046

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Alleganey
City or town: Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Alleganey
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. E Daryeville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Roger Lee Perry

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Infant
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 23 -1948
8. AGE: Years: Months: 1 Days: 6 wk If less than one day: hrs. min.
9. Birthplace: Frostburg Alleganey Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: James W. Perry
13. Birthplace: Alleganey Co. Md.
MOTHER 14. Maiden name: Viola M. Webster
15. Birthplace: Cumberland Md.
16. Informant: Mr. James W. Perry
Address: R.D. No. 1 Frostburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-1948 (month) (day) (year)
Cemetery or crematory: Vale Summit Methodist
Location: Vale Summit, Md.
18. Funeral director: Jacob Hafer
Address: Frostburg Md.
19. 9-8 (Date rec'd by registrar) 1948 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/7 1948, at 6:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/7 1948 and that I last saw him alive on 9/6 1948
Immediate cause of death: Bronchial pneumonia — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Earl Eugene Dye M.D. (M. D.) or other
Address: Lonaconing Md Date signed: 9/7/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

472 09047

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Maryland County Allegany

City Rural Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Rd. Ba Vue Pum (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Phillips

3.(b) Social Security Number 278-07-7028

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anna Folks

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.): June 27 1886

8. AGE: Years 62 Months 2 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace: Wales (Town, county, and state)

10. Usual occupation: Tin Mill worker

11. Industry or business: Retired

FATHER 12. Name: Rowland Phillips

13. Birthplace: Wales

MOTHER 14. Maiden name: Mary Llewellyn

15. Birthplace: Wales

16. Informant: Mrs Anna Phillips

Address: Bedford Rd Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12 48 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Sept. 12 1948 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1948 at 7 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1948 to Sept 10 1948 and that I last saw h[illegible] alive on Sept 10 1948

	DURATION
Immediate cause of death: Coronary Heart Failure	5 hrs.
Due to: Hypertension C-V-Renal	
Due to: Disease	
Other conditions: Carcinoma Lung	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: D. Rees M.D. M. D. or Other

Address: 124 Decatur St Date signed 9-10-48

Within corporate limits

DR. BRINGS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09048

CERTIFICATE OF DEATH

Reg. Dist. No. 4

59 Burn

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1DAY
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Was CUMBERLAND / Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. #2, WILLIAMS RD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~BABY GIRL~~ POWELL, SANDRA KAY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 8, 1948

8. AGE: Years	Months	Days	If less than one day
1 DAY			hrs. min.

9. Birthplace CUMBERLAND, ALLEGANY, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name BOYCE N. POWELL
13. Birthplace W. VA.

MOTHER
14. Maiden name UNGER, ELSIE
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12, 1948 (month) (day) (year)
Cemetery or crematory Paw Paw Rural
Location Paw Paw W Va (Rural)

18. Funeral director John F. Henderson
Address Paw Paw W. Va. RFD #1

19. Sept. 10, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 9, 1948 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Sept 9 1948
and that I last saw h... alive on Sept 9 1948

Immediate cause of death	DURATION
premature baby (6 months)	
Due to premature labor	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. L. Lantz
M. D. or other
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

467 09049

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

107 Geary St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Geary St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jacob A. Pryor

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Susan Bridenthal

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4 1874

8. AGE: Years	Months	Days	If less than one day
74	3	3	..... hrs. ..... min.

8. Birthplace Hancock Md.

(Town, county, and state)

10. Usual occupation Cooper

11. Industry or business

FATHER 12. Name James Pryor

13. Birthplace Md.

MOTHER 14. Maiden name Juliann Pyle

15. Birthplace Md.

16. Informant Mrs Susan Pryor

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 '48 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Steiss

Address Cumberland,

19. Sept. 10, 1948 (Date rec'd by registrar) W. K. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to Sept 7 1948 and that I last saw him alive on Sept 4 1948

Immediate cause of death	DURATION
Obstruction Bowel and Stomach (Stomach)	2 weeks
Due to Carcinoma of Liver	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. Allen E. Mumma M. D. or other

Address Cumberland Md. Date signed Sept 8 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 8

09050

1. PLACE OF DEATH:

County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Nebraska County: Harlan

City or town: Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Sloan Peebles Ralston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas B. Ralston

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 26 1879

8. AGE: Years: 69 | Months: 6 | Days: 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER — 12. Name: John Peebles

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Rachael Morgan

MOTHER — 15. Birthplace: Wales

16. Informant: Mrs. Earl Sleiding

Address: Midland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 3 1948 (month) (day) (year)

Cemetery or crematory: Orleans Cemetery

Location: Orleans, Nebraska

18. Funeral director: M. Eichhorn

Address: Lonaconing, Maryland

19. September 29 1948 (Date rec'd by registrar) Lucretia M. Beal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Sept 1948 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 26 Sept 1948 to 28 Sept 1948 and that I last saw h[illegible] alive on 27 Sept 1948

Immediate cause of death	DURATION
acute Congestive Heart failure	
Due to: Hypertension & Coldiac enlargment	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of Injury: ... Injured at work?

23. SIGNATURE: John B. Davis M. D. or other

Address: Frostburg, Md. Date signed: 9/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09051

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MR. GEORGE RAY

3.(b) Social Security Number 232-01-2829

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	~~WIDOWED~~ Married

6.(b) Name of husband or wife ADA ANN Iman Ray

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 3-27-1878

8. AGE: Years 70 Months 5 Days 27 If less than one day ..... hrs. ..... min.

9. Birthplace Greenland, Grant County, West Virginia
(Town, county, and state)

10. Usual occupation BLACKSMITH

11. Industry or business .....

FATHER
12. Name JACOB RAY
13. Birthplace W. VA.

MOTHER
14. Maiden name MARY HINES
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27 1948 (month) (day) (year)

Cemetery or crematory I. O. O. F. Cem

Location Elk Garden, W. Va.

18. Funeral director Otha F. Shapless

Address Blaine, W. Va.

19. Sept. 25 1948 W. R. Mantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 24 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept 24 1948 and that I last saw h.. alive on Sept 24 1948

Immediate cause of death	DURATION
Uremia	
Due to, Cardio vascular disease - Enlarged	
Due to, prostate	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. A. Gracie M. D. or other

Address Cumberland Date signed Sept 24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160

09052

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

M C I

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Central Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Edward Pinker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 29, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	19 hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Louis G. Pinker

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Mary V. Winebrenner

15. Birthplace: Frostburg, Md.

16. Informant: Louis G. Pinker

Address: 419 Central Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1948 (month) (day) (year)

Cemetery or crematory: Finks Cemetery

Location: Pleasant Union, Pa.

18. Funeral director: John J. Roche

Address: Cumberland, Md.

19. Oct. 1 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30, 1948, at 4:30 P.M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept 30 1948 to Sept 30 1948 and that I last saw h alive on Sept 30 1948

Immediate cause of death: Atelectasis Pneumonia DURATION

Due to: Premature Birth

Due to: Congenital Hepatitis

Other conditions: Jaundice

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09053

9

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany Co

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occured:

Memorial Hospital

How long in hospital or Institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: R.D. #1 Frostburg, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 217

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Ryan

3.(b) Social Security Number: 213-09-6513

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ryan

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 25th. 1879

8. AGE:

Years	Months	Days	If less than one day
68	8	12	...hrs. ...min.

9. Birthplace: Ocean Allegany, Md.

(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mines

FATHER

12. Name: Michael Ryan

13. Birthplace: Ocean, Md.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mary Ryan

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-10-1948 (month) (day) (year)

Cemetery or crematory: St. Machado's

Location: Frostburg, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 9-8 1948 Mrs. Nancy V. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/7 1948 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 9/7 1948 and that I last saw h.e.m. alive on 9/6 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Uremia	
Due to Arteriosclerotic Cardio	
Due to Vascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Dry M.D.

M. D. or Coroner

Address: Lonaconing, Md. Date signed: 9/7/48

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09054

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County PENDELTON

City or town SMOKE HOLE (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. BENJAMIN F. SHREVE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife SARAH JUDY 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 2, 1860

8. AGE:

Years	Months	Days	If less than one day
88	0	12	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation RETIRED FARMER

11. Industry or business

FATHER 12. Name BENJAMIN SHREVE

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name LUCINDA McULTY

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17, 1948 (month) (day) (year)

Cemetery or crematory Shreve Family

Location Smoke Hole, W. Va.

18. Funeral director Rogers Funeral Home

Address Keyser, W. Va.

19. Sept. 18, 1948 (Date rec'd by registrar) W. L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 14, 1948 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-13- 1948 to 9-14- 1948 and that I last saw h[illegible] alive on 9-14- 1948

	DURATION
Immediate cause of death Arteriosclerosis	
Due to myocardial degeneration	
Due to	
Other conditions Benign hypertrophy prostate	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D. M. D. or other

Address Cumberland Md Date signed 9-17-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 b

09055

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred: 14 S Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 S Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Fannie Inay (Saville) Sivville

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Sivville

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 17 1867

8. AGE: Years	Months	Days	If less than one day
81	5	14	____ hrs. ____ min.

9. Birthplace: Winchester Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER

12. Name: Louellions Miller

13. Birthplace: Va.

MOTHER

14. Maiden name: Clara Martin

15. Birthplace: Va.

16. Informant: Mrs Clara Corbin

Address: Cumberland

17. Burial (Burial, cremation, or removal) Which?) Date thereof: Sept 3 '48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md.

18. Funeral director: Louis Steinberg Inc

Address: Cumberland.

19. Sept. 3 1948 (Date rec'd by registrar) W R Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1st 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw h alive on August 31 1948

	DURATION
Immediate cause of death: Cerebral Thrombosis.	4 hours
Due to: Arteriosclerosis	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W R Beatty M. D. or other

Address: ____ Date signed: 9-3-48

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09056

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 - 10 - 6

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 645 Henderson Blvd. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Cecelia Taylor

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Elmer E Taylor

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 30 1878

8. AGE: Years: 69 Months: 10 Days: 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housework at Home

11. Industry or business:

FATHER 12. Name: Casper Rohman

13. Birthplace: Md.

MOTHER 14. Maiden name: Mathilda Ehrhart

15. Birthplace: Md.

16. Informant: Casper R Taylor

Address: La Vale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9 48 (month) (day) (year)

Cemetery or crematory: SS Peter & Paul Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Sept 8, 1948 (Date rec'd by registrar) W. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1948 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 1948 to Sept 6 1948 and that I last saw h alive on Sept 6 1948

Immediate cause of death: Auricular Fibrillation — DURATION: 11 days

Due to: Hypertension & Arteriosclerosis — years

Due to: ____

Other conditions: Diabetes Mellitus years?

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M.D. or other

Address: 41 Greene St. Date signed: Sept 8 1948

Dr Schindler

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09057

159

CERTIFICATE OF DEATH

Reg. Diat. No. 4

M

C

I

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da

Hospital, institution or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Donald David Thomas Twin #2

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 13 1948

8. AGE: Years | Months | Days | If less than one day: hrs. min.

1

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name Richard Donald Thomas

13. Birthplace Akron, Ohio

MOTHER

14. Maiden name Virginia Catherine Wheeler

15. Birthplace Mathias, W. Va.

16. Informant ~~Mother~~ Mrs R.D. Thomas

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15 48 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Lyons Stein Inc

Address Cumberland

19. Sept 15 1948 (Date rec'd by registrar) W.R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 4 25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 (8:42 AM) 48 to Death 19

and that I last saw h.i.m. alive on 13 Sept (9 PM) 1948

Immediate cause of death	DURATION
Respiratory Failure	
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leland A. Lawson MD

M. D. or other

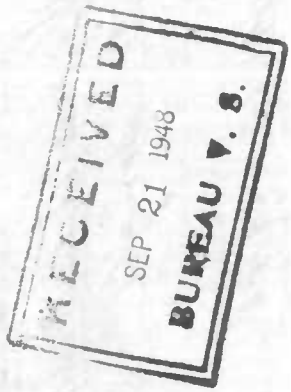
Address 41 Greene St. Date signed 15 Sept 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Ransone.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

09058

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 710 Elm Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 710 Elm St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Patrick P. Warner

3.(b) Social Security Number: 705-09-3701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Jennie (Robinett) Warner
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): December 5, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	23	hrs. min.

9. Birthplace: Elkin Garden W.Va. (Town, county, and state)
10. Usual occupation: B&O R.R. Switch Tender
11. Industry or business: B&O R.R.

FATHER
12. Name: George M. Warner
13. Birthplace: Parkersburg W.Va.

MOTHER
14. Maiden name: Susen M. Kenney
15. Birthplace: Springfield W.Va.

16. Informant: Jennie Warner
Address: 710 Elm St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1948 (month) (day) (year)
Cemetery or crematory: Hillcrest
Location: Cumberland, Md.

18. Funeral director: James F. Scarpelli
Address: Cumberland, Md.

19. Sept 29, 1948 (Date rec'd by registrar) Wm. L. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28, 1948, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1948, to Sept 28, 1948, and that I last saw him alive on Sept 25, 1948

Immediate cause of death	DURATION
Cachexia	
Due to: Adeno carcinoma Head of pancreas	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Adeno carcinoma head of pancreas — Date of op. Aug 11, 1948

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged, statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): No
Means of injury: Injured at work?

23. SIGNATURE: Wyker M Farr Jr M.D. M. D. or other
Address: Cumberland Md Date signed: Sept 28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b

09059

CERTIFICATE OF DEATH

Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Franklin Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Kate Aldridge Williams

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24 1873

8. AGE:

Years	Months	Days	If less than one day
74	10	8	hrs. min.

9. Birthplace: Frostburg, Md. (Town, county, and state)

10. Usual occupation: Brakeman on R. R.

11. Industry or business: C & P Railroad

FATHER

12. Name: James Richard Williams

13. Birthplace: Virginia

MOTHER

14. Maiden name: Jemima Middleton

15. Birthplace: Flintstone Md.

16. Informant: Miss Bertie Williams

Address: Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4th 1948 (month) (day) (year)

Cemetery or crematory: St. George Episcopal Cemetery

Location: Mt Savage, Md.

16. Funeral director: M. Eichhorn

Address: Lonaconing Md.

19. Sept 3 1948 (Date rec'd by registrar) Veronica McDermett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1st 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1948 to 9-1 1948 and that I last saw him alive on September 1 1948

Immediate cause of death	DURATION
Cardiac failure	about
Mitral & aortic Stenosis	years.
Due to: Vascular Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M. D. or other

Address: Mt Savage Md. Date signed: 9-3-1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09060

09060

Within corp. DR W.F. WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

BC Reg. Dist. No. 4

M

L

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ~~BALTIMORE~~

City or town BALTIMORE (If outside city or town limits, write RURAL and give nearest town)

Street No. 422 elrino st (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME EARL FRANKLIN WOLFE

3. (b) Social Security Number 214-07-4816

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CARRIE JEFFERSION 6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) JUNE 4, 1948

8. AGE: Years	Months	Days	If less than one day
34	3	13	..... hrs. ..... min.

9. Birthplace maryland (Town, county, and state)

10. Usual occupation GLENN L. MARTIN

11. Industry or business INSPECTOR

FATHER 12. Name EARL WOLFE

FATHER 13. Birthplace MARYLAND

MOTHER 14. Maiden name MARY JENKINS

MOTHER 15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19 1948 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director John J. Stahler

Address Cumberland, Md.

19. Sept. 17, 1948 (Date rec'd by registrar) W. P. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH SEPT 17 1948 at 11:00 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 9-12-1948 to 9-17-1948 and that I last saw him alive on 9-17-1948

Immediate cause of death	DURATION
Cardio vascular	
Due to Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 9-17-48

Within corporate limits DR. CAWLEY

09061

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 33 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town FORT ASHBY
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME MRS. LORETTA WOLFORD

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife EARL BERNARD WOLFORD

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) JULY 28, 1910

8. AGE: Years	Months	Days	If less than one day
38	1	10	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name CORBIN, BENJAMIN

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name Laverne Urice ~~LA VALLE~~

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE.,

17. Burial Date thereof Sept. 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Ashby Cemetery

Location Ft. Ashby, W. Va.

18. Funeral director John J. Hughes

Address Cumberland, Md.

19. Sept. 9 1948 W. L. Fauntz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 8 1948 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 6 1948, to SEPT 8 1948 and that I last saw her alive on SEPT. 7th 1948

Immediate cause of death	DURATION
METASTATIC CARCINOMA, LUNGS	6 WKS.
Due to PRIMARY CARCINOMA, LEFT BREAST	1 YR, 9 MOS.
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations CARCINOMA, LEFT BREAST - METASTATIC GLANDS Date of op. 12/20/46

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Cawley M.D.
M. D. or other

Address Memorial Hosp. Cumberland Date signed 9/8/48